

BOARD OF PUBLIC WORKS AND SAFETY
Agenda Request Form

(Form B-01-2012)

Organizations and individuals are asked to submit a request form and supporting documents to be placed on the agenda. You will be contacted by the City confirming the date of the meeting in which your request will be heard. Please make sure that your contact information is accurate in case we need to get in touch with you. The Board of Works meets on the 1st and 3rd Monday of each month at 5:00 p.m. in City Hall located at 70 E. Monroe Street.

Date Submitted:	1/27/2016	Meeting Date:	02/01/2016
Contact Information:			
Requested by:	Clerk Treasurer – Jayne Rhoades		
On Behalf of Organization or Individual:			
Telephone:	317-736-3609		
Email address:	jrhoades@franklin.in.gov		
Mailing Address:	70 East Monroe Street		
Describe Request:			
Transfer of current Term Life and Accident policies to Guardian Life Insurance Company			
List Supporting Documentation Provided:			
Proposal and Application			
Who will present the request?			
Name:	Jayne Rhoades	Telephone:	317-736-3609

In order for an individual and/or agency to be considered for new business on the Board of Works agenda, this reservation form and supporting documents must be received in the Mayor's office no later than 4:00 p.m. on the Wednesday before the meeting.

PROPOSAL FOR

City of Franklin

RATES SHOWN ARE VALID FROM:

August 1, 2015 - September 15, 2015

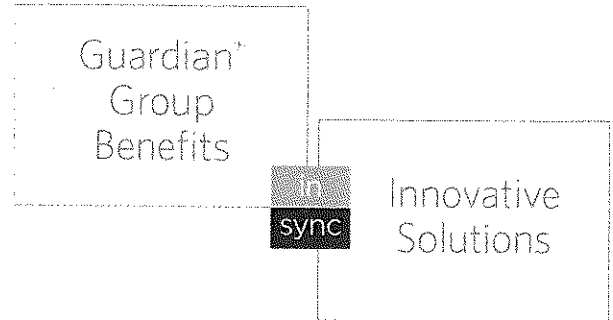
Presented by: John W. Auld & Co., Inc

Sales Representative: Andrew Racek

Telephone: (412) 505-2225

SIC Code: 9111 State & Zip: IN 46131

Created: July 16, 2015



PLAN DESIGN

We offer comprehensive benefits plans that can be customized to the needs of employers. To help you evaluate the plans, we have provided detailed benefits summaries within this package.

RATES

Rates and premiums presented are based on the employee data submitted in your request for a proposal. Final rates and premiums are based on the plans selected and the information provided on the enrollment forms.

BROAD RANGE OF PRODUCTS

We offer a variety of flexible, cost-effective employee benefits plans that can help employers meet the needs of employees and their families, and manage costs at the same time. Our benefits plans include Dental, Disability, Life, Vision, Critical Illness, and many more.

WHY GUARDIAN?

- **Enrollment Support** – Dedicated professionals help ensure smooth plan implementation
- **Multi-Product Discounts** – Combine plans to meet customer needs and save money
- **Convenient Access to Service** – One phone number and one secure website
- **Streamlined Billing** – All plans billed on one invoice
- **Experience & Expertise** – Over 50 years group benefits experience with exemplary ratings



DENTAL | DISABILITY | LIFE | VISION | CRITICAL ILLNESS | CANCER | ACCIDENT

Voluntary Term Life

City of Franklin
John Auld

RATES per \$1,000

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rates	\$0.086	\$0.092	\$0.126	\$0.199	\$0.314	\$0.474	\$0.778	\$1.284	\$2.009	\$4.053
Census					Child					
40					\$0.171					
Rate Guarantee	2 Years									
Minimum Participation	Voluntary, Greater of 25% or 10 enrolled employees.									
Underwriting Requirements	Employee <65	Spouse <65	Child	Employee 65<70	Spouse 65<70	Employee 70+	Spouse 70+			
Guarantee Issue	\$100,000	\$10,000	\$10,000	\$50,000	\$10,000	\$10,000	\$10,000	\$0		

BENEFITS

All Eligible Employees											
Employee Benefit	\$10,000 to \$150,000 in \$10,000 increments										
Spouse Benefit	50% of employee amount, Max: \$75,000										
Child Benefit	25% of employee amount, Max: \$10,000										
Dependent Age Limits	14 days to 26 years (26 if full time student). Spouse terminates at 70.										
Accelerated Life	50% of the death benefit, Minimum: \$10,000, Maximum: \$250,000										
Waiver of Premium	If disabled, insurance will continue until age 65 or no longer disabled										
Portability	Included, without Evidence of Insurability										
Conversion	Included										
Seatbelt/Airbag	Employee: \$10,000/\$15,000, Dependent: \$5,000/\$7,500										
Benefit Reduction (of original amount)	<table> <tr> <th>Age</th><th>Reduction</th></tr> <tr> <td>70</td><td>35%</td></tr> <tr> <td>75</td><td>50%</td></tr> <tr> <td>80</td><td>65%</td></tr> <tr> <td>85</td><td>75%</td></tr> </table>	Age	Reduction	70	35%	75	50%	80	65%	85	75%
Age	Reduction										
70	35%										
75	50%										
80	65%										
85	75%										

PLAN HIGHLIGHTS

- **Will Prep Services:** Provides resources to prepare wills and other planning documents. Will Prep Services include: free Estate Planning documents, access to Estate Planners and Resource Library. For a small fee, Attorney Assisted Will Preparation is also available

IMPORTANT NOTES

Rates and premiums are based on the employee data submitted. Final rates and premiums are based on the plan and employee/dependent data provided on the enrollment forms. State specific requirements may apply.

- Life rate valid for life only coverage.
- Rates are based on Actual census provided for both Enrolled employees and Volume.
- Waiver: must be disabled prior to age 60. Total Disability is required.
- Portability ceases on attainment of age 70.
- Spouse rate is based on employee's age bracket. Child rate is a per \$1,000 for all children. Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex.

SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS

Life Plan

- In order to be eligible for coverage: Employees must be legally working (a) in the United States or (b) outside the United States, for a US based employer, in a country or region approved by Guardian.
- We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. GP-1-A-GP-90-1-et al.
- Employees must be working full-time on the effective date of your coverage; otherwise, coverage becomes effective after the completion of the specific waiting period.
- Evidence of Insurability is required for all late enrollees. Benefit increases may require underwriting.

(continued)

SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS (continued)

- Guardian Voluntary Term Life Insurance is underwritten by The Guardian Life Insurance Company of America, New York, NY and will not be effective until approved by a Guardian underwriter. This proposal is subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description; plan documents are the final arbiter of coverage.

WEEKLY RATES	
Employee	\$3.65
Employee & Spouse	\$6.91
Employee & Child	\$7.17
Family	\$10.43
Census	40
Rate Guarantee	2 Years
BENEFITS	
	All Eligible Employees
Schedule	Advantage Plan
Contribution/Participation	Voluntary / 5 enrolled employees
Accident Coverage	Off Job
Accidental Death and Dismemberment	
Death Benefit	Employee: \$25,000 Spouse: \$12,500 Child: \$5,000
Catastrophic Loss	Quadriplegia: 100% of AD&D Loss of speech and hearing (both ears): 100% of AD&D Loss of cognitive function: 100% of AD&D Hemiplegia: 50% of AD&D Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D
Common Disaster	200% of Spouse AD&D benefit
Dismemberment	
Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: \$10,000 Airbags: \$15,000
Reasonable Accommodation to Home or Vehicle	\$2,500
Wellness Benefit	Provides a \$50 per year benefit for completing certain routine wellness screenings or procedures (refer to Plan Highlights section for example procedures).
Portability	Included without Evidence
Child(ren) Age Limits	Birth to 25 years (25 if full time student), subject to state limitations
Accident Emergency Treatment	\$175
Accident Follow-Up Visit - Doctor	\$50 up to 6 treatments
Air Ambulance	\$1,000
Ambulance	\$150
Appliance	\$125
Blood/Plasma/Platelets	\$300
Burns (^{2nd} Degree/ ^{3rd} Degree)	9 sq inches to 18 sq inches: \$0/\$2,000 18 sq inches to 35 sq inches: \$1,000/\$4,000 Over 35 sq inches: \$3,000/\$12,000
Burn – Skin Graft	50% of burn benefit
Child Organized Sport	20% increase to child benefits

(continued)

BENEFITS (continued)

	All Eligible Employees
Chiropractic Visits	\$25 per visit up to 6 visits
Coma	\$10,000
Concussions	\$75
Dislocations	Schedule up to \$4,400
Diagnostic Exam (Major)	\$150
Emergency Dental Work	\$300/Crown \$75/Extraction
Epidural Pain Management	\$100, 2 times per accident
Eye Injury	\$300
Family Care	\$20/day up to 30 days
Fracture	Schedule up to \$5,500
Hospital Admission	\$1,000
Hospital Confinement	\$225/day – up to 1 year
Hospital ICU Admission	\$2,000
Hospital ICU Confinement	\$450/day – up to 15 days
Initial Physician's office/Urgent Care Facility Treatment	\$75
Knee Cartilage	\$500
Joint Replacement (hip/knee/shoulder)	\$2,500/\$1,250/\$1,250
Laceration	Schedule up to \$400
Lodging	\$125/day, up to 30 days for companion hotel stay
Occupational or Physical Therapy	\$25/day up to 10 days
Prosthetic Device/Artificial Limb	1: \$500 2 or more: \$1,000
Rehabilitation Unit Confinement	\$150/day up to 15 days
Ruptured Disc with Surgical Repair	\$500
Surgery (Cranial, Open Abdominal, Thoracic)	Schedule up to \$1,250 Hernia: \$150
Surgery – Exploratory or Arthroscopic	\$250
Tendon/Ligament/Rotator Cuff	1: \$500 2 or more: \$1000
Transportation	\$500, 3 times per accident
X-Ray	\$30

PLAN HIGHLIGHTS

- Wellness Benefit includes coverage for screenings & procedures such as well visits, mammography, colonoscopy, pap smear, PSA, Serum cholesterol test, completion of smoking cessation and weight reduction programs and many more.
- No underwriting required.

IMPORTANT NOTES

The benefits listed are payable if the service, treatment or procedure is due to injuries incurred in a covered accident.

- Appliance** - Benefit is paid if a wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck is prescribed by a physician as necessary due to an injury sustained as the result of a covered accident.

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IMPORTANT NOTES (continued)

- **Child Organized Sport** - Benefit is paid if the covered accident occurred while your covered child is participating in an organized sport that is governed by an organization and requires formal registration to participate. This benefit is only payable if child coverage is included on the plan.
- **Family Care** - Benefit is payable for each child attending a Child Care center while the insured is confined to the hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.
- **Lodging** - Benefit is paid for a companion's hotel stay while the insured is confined to the hospital as the result of a covered accident. The hospital must be more than 50 miles from the insured's residence.
- **Transportation** - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.

SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS

- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year ; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.
- This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.
- This proposal is hedged subject to satisfactory financial evaluation.

This plan will not pay benefits for any injury caused by or related to:

- Declared or undeclared war, act of war, or armed aggression; taking part in a riot or civil disorder; or commission of, or attempt to commit a felony; Intentionally self inflicted injury, while sane or insane; suicide or attempted suicide, while sane or insane.
- The covered person being legally intoxicated.
- Treatment rendered or hospital confinement outside the United States or Canada.
- Travel or flight in any kind of aircraft, including any aircraft owned by or for the employer except as a fare-paying passenger on a common carrier.
- Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting, ballooning, parachuting, and/or skydiving.
- Job related or on the job injuries.
- Injuries to a dependent child received during the birth.
- An accident that occurred before the covered person is covered by this plan.
- Sickness, disease, mental infirmity or medical or surgical treatment.

Policy #: GP-1-AC-IC-12.

Guardian's Accident Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.



The Guardian Life Insurance Company Of America | 7 Hanover Square, New York, NY 10004

Your Insurance
Broker is :

Broker Name _____

Broker Address: _____

Broker Phone: _____

Your Guardian
Representative
is :

GR Name _____

GR Address: _____

GR Phone: _____

APPLICATION FOR A PLAN OF GROUP INSURANCE

REQUESTED COVERAGE			
Applicant Name :		Coverage(s): Accidental Death & Dismemberment Life Critical Illness Accident Short Term Disability	
Address :			
City :			
State :	Zip :		

BUSINESS INFORMATION			
Types of Organization: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> S Corp <input type="checkbox"/> Other: _____		Nature of Business	
		Tax ID Number	Date Established ____/____/____
<input type="checkbox"/> Yes <input type="checkbox"/> No Has your company ever filed, or is it now in the process of filing, for bankruptcy (Chapter 7 or 11) ?			

Complete below if your company or any of its affiliates has ever applied for group insurance with Guardian.		
Company or Affiliate Name (If different from Section 1)	Plan Number	Cancellation Date ____/____/____

Worker's Compensation: Present Carrier Name:	
List Owners/Partners NOT Covered by Workers' Compensation:	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If present carrier provides life insurance, are extended benefits provided in case of disability?	

Complete below if there are any COBRA or state continuation cases.					
Employee/Dependent	Type	Reason	Continuation Dates		
Date of Birth ____/____/____	<input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> Extension of benefits	<input type="checkbox"/> Disability <input type="checkbox"/> Non-Disability	Start ____/____/____	End ____/____/____	

For additional names,
please attach a
separate sheet

HEALTH RELATED INFORMATION
Answer the following questions to the best of your knowledge for any members to be insured. The term "member" means eligible employees and their dependents and COBRA participants and their dependents. Provide details for any "Yes" response on a separate sheet. Do not disclose the name of any member.

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HEALTH RELATED INFORMATION (Continued)

- ☐ Yes ☐ No **Groups with less than 16 eligible employees :** To the best of your knowledge has any employee or dependent, within the past three years, been treated for or diagnosed as having: cancer, heart disease, kidney disorder, liver disorder, stroke, or other serious or debilitating illness?
- ☐ Yes ☐ No Are any employees currently not actively at work? If Yes, please complete the supplemental Actively at Work statement.
- ☐ Yes ☐ No **Groups with less than 16 eligible employees :** Has any current member, within the past 12 months, missed 30 or more days due to any serious or debilitating illness or injury?

AGREEMENT**Conditions Of Agreement**

It is understood that only full-time employees shall be eligible.

Full-time employee means one who regularly works the number of hours in the normal work week established by this applicant (but not less than 30 hours per week) at the applicant's normal place of business.

Insurance Broker Representation: It is further understood that no broker has power on behalf of The Guardian Life Insurance Company of America to make or modify any request or application for insurance, or to bind said Insurance Company by making any promise or representation or by giving and receiving any information.

Acceptance of Plan

It is further understood that no insurance will be effective until the plan is accepted in writing by the Insurance Company(-ies). No contract of insurance is to be implied in any way on the basis of the completion and submission of the application.

Upon acceptance, this application will be attached to and made part of the Group Insurance Policy.

Fraud Warning:

Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

The undersigned applicant certifies that to the best of his/her knowledge and belief, all of the responses given are true, correct and complete. The applicant understands that a false statement or misrepresentation in the application may result in loss of coverage in the policy, the rescission of the policy, or a revision of the rates quoted.



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SIGNATURES			
I have reviewed the statements made by me on this application, and they are true and complete to the best of my knowledge and belief. By my signature below, I acknowledge that _____ endorses the Guardian plan of insurance.			
Officer, Partner or Proprietor Signature		Witness Signature	
X	Date / /	X	Date / /
Title		Title	
Insurance Broker Signature		Additional Insurance Broker Signature	
X	Date / /	X	Date / /
Print Name		Print Name	
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Group Plan Number _____

Requested Effective Date / /



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